PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council held Tuesday, April 19, 2005, 10:00 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Paul J. Cote, Jr., Commissioner, Department of Public Health, Ms. Maureen Pompeo, Mr.Albert Sherman, Ms. Janet Slemenda, Dr. Thomas Sterne, and Mr. Gaylord Thayer, Jr.. Absent Members were: Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Dr. Martin Williams and Donna Levin, General Counsel. Also in attendance was Attorney Susan Stein, Acting General Counsel.

Commissioner Cote, Chair, announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance. Chair Cote also noted that docket item #4 would be heard prior to docket item #3 and the staff presentation.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Ms. Sally Fogerty, Associate Commissioner, Center for Community Health; Dr. Ellen Nelson, Associate Commissioner for Clinical and Laboratory Services; Dr. James K.West, Center for Health Information, Statistics, Research and Evaluation; Ms. Louise Goyette, Director, Office of Emergency Medical Services; Deputy General Counsels: Steven Chilian and Carol Balulescu, Office of the General Counsel; Ms. Joan Gorga, Acting Director, Mr. Jere Page, Senior Program Analyst, and Mr. Bernard Plovnick, Consulting Program Analyst, Determination of Need Program; and Ms. Brunilda Torres, Director, Office of MultiCultural Health.

RECORDS:

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the Records of the Public Health Council Meetings of December 21, 2004 and February 22, 2005.

PERSONNEL ACTIONS:

In letters dated April 7, 2005, Val W. Slayton, MD, MPP, Chief Medical Officer, Tewksbury Hospital, Tewksbury, recommended approval of appointments and reappointments to the various medical and allied health staffs of Tewksbury Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) That, in accordance with the recommendation of the Chief Medical Officer of Tewksbury Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following appointments and reappointments to the various medical and allied health staffs of Tewksbury Hospital be approved for the period of April 1, 2005 to April 1, 2007:

APPOINTMENTS:	MASS. LICENSE NO.:	STATUS/SPECIALTY:
Laurie Humbert, PhD	3766	Provisional Allied Staff/Psychology
Elina Wayrynen, PhD	7198	Provisional Allied Staff Psychology

REAPPOINTMENTS:	MASS. LICENSE NO.:	STATUS/SPECIALTY:
Mark Albanese, MD	71493	Consultant Staff Psychiatry
Asha Garg, MD	46368	Consultant Staff/Physical Rehab.Medicine
Michael John, DMD	13404	Active Staff Dentistry
Robert Karr, MD	73911	Active Staff Psychiatry
Edward Khantzian, MD	28153	Active Staff Psychiatry
Harvey Pinsky, PhD	1719	Allied Staff Psychology
Anthony Vagnucci, MD	158102	Active Staff Psychiatry

In a letter dated April 1, 2005, Blake Molleur, Executive Director, Western Massachusetts Hospital, recommended approval of a reappointment to the active medical staff of Western Massachusetts Hospital. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously) That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following reappointment to the active medical staff of Western Massachusetts Hospital be approved:

REAPPOINTMENT:	MASS. LICENSE NO.:	STATUS/SPECIALTY:
Kollegal Murthy, MD	56320	General Medicine/Geriatrics

In a letter dated April 11, 2005, Paul Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of appointments and reappointments to the various medical and allied health staffs of Lemuel Shattuck Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) That, in accordance with recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following appointments and reappointments to the various medical and allied health staffs of Lemuel Shattuck Hospital be approved:

APPOINTMENTS:	MASS. LICENSE NO.:	STATUS/SPECIALTY:
Ashish Mahajian, MD	222613	Consultant/Internal Medicine
David Stockwell, MD	205222	Consultant/Internal Medicine, GI
REAPPOINTMENTS:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Hilary Aroke, MD	210218	Internal Medicine
Frank Davidson, MD	33520	Internal Medicine, Pulmonary
Daniel Matloff, MD	40154	Active/Internal Medicine GI
Juan Vera, MD	42125	Consultant/Internal Medicine/Oncology
Frederick Doherty, MD	34487	Consultant/Radiology
Nayer Nikpoor, MD	73739	Consultant/Radiology
Daniel O'Leary, MD	32840	Active/Radiology

Joseph Santoro, MD	213293	Consultant/Radiology
Hassam Batal, DMD	20681	Consultant/Dentistry
REAPPOINTMENTS:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Ronald Nasif, MD	46262	Consultant/Orthopedic Surgery
Carol Walsh, NP	106000	Allied Health Professional/Medicine

In a letter dated April 11, 2005, Dr. Ellen Nelson, Associate Commissioner for Clinical and Laboratory Services, Department of Public Health, and Arthur M. Pappas, Chairman, Board of Trustees, Massachusetts Hospital School, recommended approval of the appointment of Doreen C. Harper, PhD, RN,ANP, FAAN to the Board of Trustees of Massachusetts Hospital School, presently serving as Dean, University of Massachusetts, Worcester, Graduate School of Nursing. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously) That, in accordance with recommendation of the Associate Commissioner for Clinical and Laboratory Services, Department of Public Health, and Dr. Arthur M. Pappas, Chairman, Board of Massachusetts Hospital School, under the authority of the Massachusetts General Laws, chapter 111, §3A, the appointment of Doreen C. Harper to the Board of Trustees at the Massachusetts Hospital School be approved:

In a letter dated April 11, 2005, Dr. Ellen Nelson, Associate Commissioner for Clinical and Laboratory Services, Department of Public Health, recommended approval of the reappointment of Dr. Arthur M. Pappas, presently serving as chairman of the Board of Trustees of the Massachusetts Hospital School. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously) That, in accordance with recommendation of the Associate Commissioner for Clinical and Laboratory Services, Department of Public Health, under the authority of the Massachusetts General Laws, chapter 111, §3A, the reappointment of Dr. Pappas to the Board of Trustees at the Massachusetts Hospital School be approved:

APPOINTMENT:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Doreen C. Harper, PhD	RN: 241150	Trustee/Health Care Administration
REAPPOINTMENT:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Arthur M. Pappas, MD	27259	Trustee/Orthopedics & Physical Rehabilitation

MISCELLANEOUS: REQUEST FOR ADOPTION OF NEW GOVERNING BODY STRUCTURE AND BYLAWS FOR THE PUBLIC HEALTH HOSPITALS:

Dr. Ellen Nelson, Associate Commissioner, Center for Clinical and Laboratory Services, Department of Public Health, presented the request for adoption of new governing body structure and bylaws for the Public Health Hospitals. Dr. Nelson said in part, "…We are in the process, within the Department of Public Health, in cooperation with the Department of Mental Health, of revising the Governing Body Structure of the four Public Health hospitals run by the Department of Public Health. This is an effort to meet standards for Medicare and Medicaid reimbursement, and also to meet JCHO accreditation at a national level, and it is similar to what you would find in any hospital system in the country these days. The revisions were meant to allow integration of health and mental health services, and a joint oversight by the Department of Public Health and the Department of Mental Health. This does not, in any way, alter the existing Boards of Trustees at

two of the hospitals. Two of the hospitals, as you know, have Boards of Trustees, Mass. Hospital School and Tewksbury Hospital. The membership of those boards remains intact, as does the structure at this point. This is an attempt at organizing ourselves to oversee all four hospitals and bringing the two departments together in a contemporary manner of management."

Council Member Thayer, Jr. said, "I read this over more than one time in the last several days and frankly, I don't understand what is going on. Governance is a big issue these days, whether it is the private sector or the public sector, it gets a lot of exposure. In my experience, when proposing an organizational change, we are very much interested in seeing what the overlay was, what was wrong with it, what the new way is, how it fixes, what the benefits are in terms of the Department of Public Health and the Commonwealth, what benefits are ensured to the residents of the Commonwealth. I didn't find that here. I am disinclined to vote for this because I don't know what is going on. How we govern these hospitals, I think is a big deal."

Dr. Nelson replied, "One of the determinants, if I can respond to that, was a review by CNS at Tewksbury Hospital, finding fault with the former governing structure. We used that as a guideline early on as to how can we correct that end. In doing that one corrective plan, it made sense at that time to do something systematic for the hospital. So, the former governance structure, that currently is in existence, that we are asking to disband to replace with the new one, did not meet those standards and, therefore, what the attempt was, was to correct what was necessary and also bring the Department of Public Health closer to the Department of Mental Health because in two of the hospitals, Tewksbury and Shattuck, these are joint services and, in the past, the coordination wasn't up to what was considered appropriate by our oversight at the federal level to assure reimbursement. One of the reasons we are changing is to make sure we are in compliance with the conditions for participation so that we get the federal match for Medicaid and Medicare in the state, and we tried to do that in the simplest format, as opposed to doing something radical, or substantial I suppose."

Council Member Thayer responded, "I understand there is a history. Hopefully a rational process was followed. I would like to see in here what was the problem, what caused it, how does this fix it, and apparently, if we are applying the same solutions at other institutions, why, the reasons for that." Council Member Sherman asked if there are time constraints concerning the passing of this governance structure. Dr. Nelson responded, "The time constraint is that we are not necessarily in compliance at this point with federal law."

Attorney Steven Chilian, Deputy General Counsel, Department of Public Health, addressed the Council, "I am the attorney for the Public Health Hospitals. Essentially, one of the big issues that we have at the Public Health hospitals is, we do have integrated services in two of the hospitals, the Tewksbury and the Shattuck Hospital. We have a Department of Mental Health and we have a Department of Public Health. People receive services and it really hasn't been a major problem. The problem is, JCAHO wants clear integration, functional integration with those two facilities. You really can't have a psychiatric medical director and a DPH medical director, and it has to be one organization that works as one organization and the great emphasis upon what we are doing here is to bring that integration together through the governing structure. We are going to have, if you look at the documents, which I am sure you have taken a very close look at those, you will note that one of the key points is, in the past, we have always had a joint arrangement with both agencies, an agreement to

provide services and to share certain things, and to work together. Well, unfortunately, that really hasn't worked well and, as I pointed out, you have people in a hospital, instead of being hospital representatives, they are either a DMH representative or DPH representative. One of the key functions here is the Joint Services Agreement, which will really allow the groups to coordinate those services, but will be accountable to the governing body, a governing body that will include people that, in the past, haven't been involved in hospital operations. You will have the DMH Commissioner and the DPH Commissioner, and Health and Human Services. You will have more people brought to bear on the operation of hospitals than were able to do that in the past and, by doing so, marshal more resources to be able to, in a more timely manner, effect things that need to be changed in the hospitals."

Attorney Chilian continued, "Quite frankly, we have seen an evolution over the past ten years, from one person being the governing body of an entire hospital, to a group of four, now to a larger body. This is something that is not only good and adds value to the operation, but it is something really that is required under federal laws. JCAHO wants to see everyone at the hospital working together. They don't want to see a separate department of medicine and separate department of psychiatric services, both basically working for different agencies. They want to know that, when they come here, it is a hospital focused basically as one operation. This is basically an evolution that we sort of started many years ago and, as we have discovered other areas that need to be changed, we have dealt with them. This is not going to stop today or tomorrow. Our hope basically is to, over the next year put this together, to keep on refining, to get to the point where, not only does it meet JCAHO and CNS, but it also adds greater value to the operation of the hospitals. We have worked on this thing for a very lengthy period of time with both agencies. Certain people in this room have been very much involved. It is something that we really want to get moving forward as quickly as possible because right now we really don't have a functional governing body. I say that as the Attorney for the hospitals. We need to move forward as quickly as possible. It doesn't mean we may not come back in six months and, if you would like, we can provide a status report in the next six months that tells you where we are at with this, and how far we are going. Our intention, basically, is this is a living document that will change over time, but it needs to start today. I realize this is a large document to digest, but it really is something that has taken a great many people many hours to work out, and I can tell you now that it is a vast improvement over the way we had it in the past. It may need some changes down the road. We may be back here in less than six months to make some refinements, but it is a living organization. It needs some greater focus on it, and we think this is probably the best way to do it at this point in time."

Council Member Pompeo stated, "One of the issues that is prompting the concern is the origin of this change. Most of us are familiar with what happened two years ago and I think that is the problem, because we are not seeing this in the context of the overall plan, we are dealing with those types of issues."

Attorney Chilian replied, "Let me explain, part of the problem we had at Tewksbury was exactly what this is about. We really had two departments, the Department of Medicine and the Department of Psychiatry that were not working together. I will say this; we were not doing a good enough job of providing them with the support that they needed. And one of the reasons why we were not doing such a good job was because we really didn't have a structure that allowed us to

do it. A case in point, the JSA (Joint Services Agreement). In the past, we had issues with the arrangement between the agencies, a very bureaucratic system. We had to get commissioners together. We had to get them to agree, and sometimes it works very well, but sometimes it doesn't. In this particular situation, we are going to have both of those organizations with a special standing committee that will be looking at those integration issues and they will have input to the governing body on a routine basis, on a monthly basis; but, more importantly, if there is a disagreement, they look at the impasse. We also have Health and Human Services. The idea is to put teeth into the arrangements that we had in the past…"

Council Member Thayer stated, "What you are saying is all very good and very helpful. The problem is, it is testing your ability and my ability to do it on the fly."

Attorney Chilian answered, "What I am suggesting to you is, if you would allow us to go forward today, we can come back in six months and give you a status report as to where we are at, how we are doing, and basically keep you involved in that manner because we really feel that this is just the first step and that things are probably going to change over time. It's like any other organization, as you try to functionally integrate, to bring organizations together that haven't worked that way in the past, you are going to run into problems that you can't foresee. We think we have done a very good job in trying to do that with this document, but we really feel, the only test to this will be putting it into play and trying to make it work. Now, that means probably coming back to you with our evaluation of things that work and maybe some things that didn't work quite as well as we thought they would work, but that's an important step for us to basically put it together and start making it work."

Council Member Pompeo asked, "What are the implications of not voting today?" Attorney Chilian responded, "…We have a lot of things to do that are basically waiting now for that governing body. There are a lot of issues that are going to need to be addressed and my feeling is that we have the capability. We have the talent to make it work. By delaying it, we are just going to create more issues than we need to at this time. I would say if you are asking me, I know I am just giving my opinion, and I know it is not worth that much here, but what I would tell you is we can come back and provide you with an update. We can bring the people actually on the governing body, if you want a demonstration of how this works, we can do all that, but I think it would be better for us to get things moving so that we can actually present that to you, so you can see how things are working. I can tell you people have worked very hard in the hospitals to make this a reality, and I realize that it is a lot to digest but I think we have done our homework. I think we are ready to put it into play. Do you have another question?"

Council Member Dr. Sterne stated, "Maybe I could pose an intermediate solution that will work for you and work better for the Council, as well. Clearly, the reason you are getting the kind of questioning that you are is because of the background that you have given us to your request for us to adopt this new structured set of bylaws. You didn't really cover much of anything of what you shared with us today. And it really didn't cover the underlying major concerns in frank language, the underlying parallel leadership problems, perhaps the unstated competition between DMH and DPH along those lines. It didn't cover any of that stuff. Usually, if we receive a request for an adoption as opposed to a request to move forward to public hearing, I think all the Council Members' expectations really are that we have a better understanding of the issues prompting

change and what is ultimately gained from that material. And because this is an adoption, and because you have not stated that there is an emergent nature to the reply to Medicare or I should say maybe we may well be in or out of compliance with some of their requirements, this wouldn't be the first time that major institutions perhaps in fact are in that state for weeks and months or longer. I am not hearing an emergent level request for promulgation today. My recommendation would be to present your request at the next meeting…table it for today, in terms of a vote, in the interim, share with us a piece of documentation that goes through the issues, that Chip and others have already eluded to in a way that we can use to make a more balanced judgment about the changes, not taking away for a split second how much work, devotion and thought you have already put into those very issues."

Attorney Chilian replied in part, "…It really is more of an emergency than you think. A lot of things we have done and are planning to do would be put back by the delay. I could go through every piece in that[the material presented to Council] with you, if you would like. This is basically a parallel governance, but the most important issue is that we have to recognize that the Joint Services, at least at two of the facilities, are very important documents to have and in the past, we never recognized that in a formal way by allowing DMH to be more involved in the operation of these hospitals, which quite frankly I hadn't been convinced before because I am a DPH guy, but now I am convinced that we really have to look at it as a joint operation, and this is the document that is going to get us to that first step. I understand you will vote to table, but I want you to understand something, that whatever presentation we give you next month, this is the information you are going to get. We cannot run facilities where we don't have the integrations necessary. I think it is a great improvement, having Health and Human Services involved, having DMH now share the table on some of the operational issues, and some of the problems we have, and I think it is a very massive document in those terms. Again, constantly having a Joint Services Agreement embodied in the governing body, as you can see in this document today, something that I have never seen anywhere else, actually having a living document that basically gets reviewed on a monthly basis, and goes to the governing body, so issues that come up get dealt with on a day-to-day basis, not when there is a crisis."

Council Member Dr. Sterne noted, "I don't challenge the content of anything that you presented but what has been most edifying to me has been the examples given, not by specifics, but the general examples given of why there was conflict and therefore the potential effectiveness in either accountability, responsibility, or decision making, and that isn't something to sort of have to absorb by example in the final meeting. That is something to have had an opportunity to absorb before the decision. Respecting everything that you say, I would still suggest to my co-workers that we [table this for the next meeting]."

Chair Cote added, "We have a suggestion to table this item until our next meeting so that we can provide further information to support the informed deliberation by the Council. Is that the pleasure of the Council?"

After consideration, upon motion made and duly seconded, it was voted (unanimously) **to table** the Request for **Adoption of New Governing Body Structure and Bylaws for the Public Health Hospitals** until the next meeting of the Council and that a copy be attached and made a part of this record as **Exhibit No. 14,808.**

STAFF PRESENTATION: "MASSACHUSETTS BIRTHS 2003", BY JAMES K. WEST, PH.D., CHIEF DEMOGRAPHER & EPIDEMIOLOGIST, CENTER FOR HEALTH INFORMATION, STATISTICS, RESEARCH AND EVALUATION:

Dr. West presented the "Massachusetts Births 2003" Report to the Council. Some highlights from the report follow:

- In 2003, Massachusetts had the second lowest Infant Morality Rate (IMR) in its history. The IMR was 4.8 infant deaths per 1,000 live births, compared with 4.9 in 2002.

- The cesarean section delivery rate in Massachusetts, 29.3%, was the highest rate ever reported.

- The percentage of low birthweight (LBW) infants (less than 2,500 grams or 5.5 pounds), 7.6%, was the highest it has been since at least 1980.

- In 2003 in Massachusetts, the average age of mothers giving birth for the first time was 29.8 years, which was the oldest in state history.

- The Massachusetts teen birth rate has decreased steadily from 35.4 births per 1,000 women ages 15-19 in 1990 to 22.6 in 2002, and remained the same in 2003.

- Births in five ethnicity groups have increased more than 10% since 2002: Japanese, Mexican, Cuban, Colombian, and "Other Central American". Despite a very small percent (less than 1%) decrease in overall births from 2002, certain groups have experienced large increases in the numbers of births.

- The percentage of women smoking during pregnancy continued its steady decline over the last 14 years. It decreased from 7.9% in 2002 to 7.7% in 2003. The percentage of smoking during pregnancy has decreased 60% since 1990, when it was 19.3%.

- The percentage of breastfeeding among mothers in Massachusetts increased from 76.1% in 2002 to 78.1% in 2003, continuing its steady increase over the last 14 years. The rate of breastfeeding has increased 50% since 1989, when it was 52.2%.

- The percentage of preterm infants (delivered before the 37th week of gestation) increased 2% from 8.5% in 2002 to 8.7% in 2003.

- Disparities by race, ethnicity, education and community persist:

    - Black non-Hispanic IMR is over 3 times that of the white non-Hispanic (12.7 vs. 4.1).
    - Teen birth rate for Hispanics is about 6 times that for white non-Hispanics (78.3 vs.13.7).

- Cambodian (54.0%), Cape Verdean (65.9%), and Haitian (66.4%) mothers are less likely to receive prenatal care in their first trimester compared with mothers in other ethnicity groups (State average: 83.9%).
- Less educated women are much more likely to smoke during their pregnancies, more likely to deliver LBW infants, and less likely to receive adequate prenatal care.

- The number of births to Massachusetts residents declined by less than 1% (0.6%) from 2002 to 2003, from 80,624 to 80,167. Since 1990, the number of births in Massachusetts has declined by 13%, and the birth rate among women of reproductive age has declined by 9% (from 62.2 to 56.2 births per 1,000 females ages 15-44). The average age of mothers at first birth was 29.8 years in 2003 compared with 27.7 years in 1999.

- The infant mortality rate (IMR) in 2003 was 4.8 infant deaths per 1,000 live births, compared with 4.9 in 2002. There was a total of 383 infant deaths in 2003, compared with 397 in 2002. The Infant Mortality Rate has decreased 31% since 1990, from 7.0 deaths per 1,000 live births to 4.8 deaths per 1,000 live births.

- Black non-Hispanic mothers continued to have the highest IMR (12.7 per 1,000 live births). Black non-Hispanics were the only group to experience an increase in IMR (9%) in 2003; whereas, IMR decreased by 21% for Hispanics (7.0 to 5.5), by 10% for Asians (3.0 to 2.7), and 2% for white non-Hispanics (4.1 to 4.0).

- In 2003, there were 15 pregnancy-associated deaths, including 4 maternal deaths. The 2003 pregnancy-associated mortality ratio (PAMR) was 18.5 deaths per 100,000 live births and the maternal mortality ratio (MMR) was 4.9 per 100,000 live births. Since 1990, the annual PAMR fluctuated from a low of 18.0 in 1990 to a high of 32.8 in 2001. However, due to the small number of deaths, the differences are not statistically significant.

- In 2003, 4,639 births occurred to Massachusetts resident women ages 15-19, which was a difference of only 3 fewer births than in this age group in 2002. Although the overall number of births declined less than 1%, the teen birth rate remained steady. The Massachusetts teen birth rate had decreased steadily from 35.4 births per 1,000 women ages 15-19 in 1990 to the current low of 22.6 in 2002, and remained the same in 2003. The Massachusetts teen birth rate in 2003 was 46% below the preliminary U.S. teen birth rate of 41.7 births per 1,000 women ages 15-19.

- The annual number of births to young teens (ages 12-14) continued to decline in 2003, from a peak of 155 in 1994 to the current low of 56 (a rate of 0.27 births per 1,000 females aged 10-14), this represents a 23% decline in births in this age group from 2002. The 2003 U.S. birth rate for younger teens was 0.70 live births per 1,000 females aged 10-14 years, 61% above the Massachusetts birth rate for young teens.

- The percentage of low birthweight among births to teen mothers was 10.3% in 2003, compared with 7.4% among births to mothers ages 20 and older in 2002.

- In 2003, among Massachusetts municipalities with the highest number of teen births, teen birth rates were highest in Holyoke (91.9), Lawrence (82.9), and Springfield (79.3). These communities had rates over three times the statewide rate of 22.6 teen births per 1,000 females 15-19.

- The percentage of low birthweight infants (less than 2,500 grams of 5.5 pounds) increased to 7.6% in 2003 from 7.5% in 2002. Since 1990, the percentage of low birthweight infants has increased by 31%, from 5.8%.

- Between 2002 and 2003 , black non-Hispanics were the only group to experience a decrease in the percentage of low birthweight infants (4%); whereas, LBW increased by 3% for white non-Hispanics(6.8% to 7.0%), by 1% for Asians (8.0% to 8.1%), and remained the same for Hispanics (8.3%).

- Between 2002 and 2003, the percentage of low birthweight infants increased slightly among singletons (5.2% to 5.3%) and among multiple births (53.0% to 55.6%).

- Very low birthweight (VLBW; infants weighing less than 3.3 pounds) has remained stable since 1999, at 1.4%. For the third year in a row, black non-Hispanic infants continue to have the highest percentage of VLBW at 3.1%, the same as in 2002.

- The percentage of preterm infants (infants delivered before the 37th week of gestation) increased 2% from 8.5% in 2002 to 8.7% in 2003. Preterm rates decreased for all race and Hispanic ethnicity groups, except for white non-Hispanic rates, which increased by 6% from 2002. Preterm rates were lowest for Asians (7.1%) and highest for black non-Hispanics (12.0%).

- The percentage of infants delivered very early (before the 28th week of gestation) has remained the same since 1997 at 0.6%. Black non-Hispanic women have the highest proportion of infants delivered very early, 1.7%, which was more than double that of any other race group.

- The percentage of births to white non-Hispanic and black non-Hispanic mothers has decreased since 1990. From 1990 to 2003, it decreased by 8%, from 78.4% to 71.9% for white non-Hispanic mothers, and by 4% for black non-Hispanic mothers, from 7.7% to 7.4%. The percentage of births to Asian mothers increased by 73%, from 3.7% to 6.5%. The percent of births to Hispanic mothers increased by 33%, from 9.1% to 12.2%.

- The percentage of births to non-U.S. born mothers increased 3% between 2002 and 2003 – from 23.3% to 24.1%. In 2003, almost 1 out of 4 births to Massachusetts residents was to a mother born outside the continental U.S., Puerto-Rico, and the U.S. Territories.

- The percentage of women who smoked during pregnancy continues its steady decline from 7.9% in 2002 to 7.7% in 2003. Decreases in smoking during pregnancy occurred among all races and Hispanic ethnicity groups except for Asians.

- Adequacy of prenatal care decreased by less than 1% from 84.7% in 2002 to 84.5% in 2003. Adequacy of prenatal care is a measure of the timing and number of prenatal care visits, not an assessment of the quality of prenatal care. [Please note: these data are not comparable to data published in reports prior to 2001. Please see the full report for more detail].

- The cesarean section delivery rate continues to increase. The cesarean section (c-section) rate among births to Massachusetts residents was 29.3% in 2003, an increase of 4% from 2002 (28.1%). There were increases in both primary and repeat c-sections. The primary c-section rate increased by 4%, from 20.5% to 21.4%, and the repeat c-section rate increased by 3%, from 85.3% to 87.5%. Concomitantly, the rate of vaginal births after cesarean section (VBAC) deliveries decreased substantially, from 14.7% in 2002 to 12.5% in 2003, a decrease of 15%.

- The percentage of mothers breastfeeding increased from 76.1% in 2002 to 78.1% in 2003, continuing the trend of steady increase from the last 14 years. The breastfeeding rate increased for all major race/Hispanic ethnicity groups, with the exception of Hispanics, for whom the breastfeeding rate decreased slightly by less than 1%. The largest increase in the percentage of mothers breastfeeding was seen among black non-Hispanic mothers (up 3.2% from the previous year).

- The percentage of mothers whose source of payment for prenatal care was public increased between 2002 and 2003, from 28.5% to 28.9%, continuing its steady increase since 1996. Mothers whose prenatal care source of payment was Medicaid were more likely to be very young mothers, to deliver LBW infants, to be unmarried, and likely to receive adequate prenatal care, to breastfeed, and to deliver by Cesarean section than mothers whose prenatal care was privately funded.

- In 2003, 95.3% of all births were singletons, 4.4% were twins (3,551 births) and 0.3% were triplets (241 births), and two sets of quadruplets. The total percentage of multiple births (twins, triplets or more) was 4.7% in 2003, which was a slight decrease of 4% from 2002 (4.9%). The percentage of multiples among births to mothers ages 35+ (7.1%) was almost double the percentage for mothers under age 35 (4.1%).

A comparison of Massachusetts and U.S. Indicators

Most Massachusetts perinatal health indicators in 2003 were better than those for the U.S. in 2003. According to preliminary U.S. birth statistics for 2003:

- The birth rate for women ages 15-44 in Massachusetts (56.2 births per 1,000 women 15-44 years) was 15% lower than the U.S. birth rate (66.1).

- The teen birth rate in Massachusetts (22.6 births per 1,000 women ages 15-19) was 46% lower than the U.S. teen birth rate (41.7).

- The low birthweight rate in Massachusetts (7.6%) was 3% lower than the U.S. low birthweight rate (7.9%).

- The preterm rate in Massachusetts (8.7%) was 29% lower than the U.S preterm rate (12.3%).

- The percentage of women receiving prenatal care in the first trimester in Massachusetts (83.9%) was slightly lower than the U.S. percentage (84.1%).

- The cesarean section delivery rate in Massachusetts (29.3%) was 6% higher than the U.S. c-section rate (27.6%).

- Accordingly to preliminary U.S. death statistics for 2003, the infant mortality rate (IMR) in Massachusetts (4.8%) was 30% lower than the U.S. IMR (6.9).

NO VOTE/INFORMATION ONLY

INFORMATIONAL BRIEFING CONCERNING PROPOSED REGULATIONS ON SMOKE-FREE WORKPLACES (105 CMR 661.000):

Ms. Sally Fogerty, Associate Commissioner, Center of Community Health, presented the Informational Briefing Concerning Proposed Regulations on Smoke-Free Workplaces to the Council. She noted that The Massachusetts Smoke-free Workplace Law (c.270, s.22) went into effect on July 5, 2004. The statute authorizes the Department of Public Health to adopt regulations to implement the statute. In general, there has been a high level of compliance with the law throughout the Commonwealth. Local boards of health are reporting a rate of 90% compliance to the Tobacco Control Program…Two areas of concern have emerged which the Tobacco Control Program is proposing to address through regulations:

1. The Tobacco Control Program has received calls from both hospitality businesses and local boards of health requesting clarification on issues related to smoking in outdoor dining areas such as patios, decks, tents and partially enclosed rooms. While the law prohibits smoking in enclosed areas of workplaces, it permits smoking in outdoor spaces of such establishments. A number of questions have arisen as to where to draw the line between enclosed and outdoor spaces. We would like to propose regulations that are consistent with the intent of the law and provide clear guidance around the amount of open space that is necessary for a space to be considered "outdoor dining".

2. Another area where the Tobacco Control Program has received feedback from the business community regards membership associations, which are also known as private clubs. The law exempts these organizations when they are not open to the public. It appears that some membership associations operate strictly as private clubs and therefore are exempt from the law. Other membership associations, however, appear to advertise to the public or permit regular access by persons who are not members of the association.

Ms. Fogerty noted further, "The Tobacco Control Program and local boards of health have received many calls from restaurant and bar owners who perceive these membership associations to be as

operating as public bars rather then private clubs. While the issue of what constitutes membership is a difficult one, we are proposing regulations to define membership that we believe to be consistent with the intent of the Smoke-free Workplace Law and policies of the Alcoholic Beverage Control Commission. If a membership association is only serving their members and is not open to the public, these regulations would have no impact on it. In addition, these proposed regulations would address two areas of the law where DPH is required to promulgate regulations: tobacco testing in professional laboratories and defining repeat offenders for purposes of enforcing the law."

NO VOTE/INFORMATION ONLY

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 170.000, EMERGENCY MEDICAL SERVICES SYSTEM REGARDING CRITICAL CARE SERVICE LICENSURE, EMT REPORTING REQUIREMENTS AND TECHNICAL CORRECTIONS:

Attorney Carol Balulescu, Deputy General Counsel, Department of Public Health, presented the request for final promulgation of amendments to 105 CMR 170.000, Emergency Medical Services System regarding critical care service licensure, EMT reporting requirements and technical corrections to the Council. She said in part, "…The amendments primarily establish a new category of ambulance service licensure for the delivery of critical care services. In addition, the amendments create new requirements for emergency medical technicians (EMTs) to report criminal convictions and adverse compliance action taken by the Department. Some technical amendments to other portions of the EMS regulations are also included. These amendments were originally presented to the Council on December 21, 2004."

Attorney Balulescu noted further, "In 2002, the Emergency Medical Care Advisory Board (EMCAB)'s Medical Services subcommittee established a Critical Care Task Force to develop and report back recommendations regarding licensure of critical care level ambulance services. Both of Massachusetts' air ambulance services and all of the Commonwealth's providers of ground critical care services were represented. After more than a year of meetings, Task Force members came to consensus on a set of recommended licensure standards based primarily on a service being accredited by the Commission on Accreditation of Medical Transport Systems (CAMTS), a national accrediting organization for ambulance services providing critical care-level EMS. The Task Force's recommendations were approved by the Medical Services committee and then the EMCAB's Executive Committee at the end of 2003. Subsequently, the Department developed draft regulations based on EMCAB recommendations, and submitted them to the members of the full EMCAB in October 2004 for their review and comment."

Staff noted that a public hearing had been held on Thursday, January 27, 2004, in Boston. Comment was accepted until Friday, February 4, 2004 at 5:00 p.m. Oral and/or written comments on these regulations were received from 15 organizations or individuals, as follows: the regional medical director for the Region V EMS Council; three physician providers of critical care ambulance transports – Monica Kleinman of Children's Hospital; Marc Restuccia of UMass Memorial Life Flight, and Richard Zane of Partners Health Care; attorneys Harold Lichten and Leah Marie Barrault on behalf of their client, the Professional Fire Fighters of Massachusetts (PFFM); the Worcester district representative of the PFFM, on behalf of the union statewide; another representative of the

PFFM; five self-identified firefighter/EMTs and five other individuals who are EMTs. In addition, the Massachusetts Call/Volunteer Firefighters Association submitted comment as part of the EMCAB process, and in accordance with past practice, the Department has considered that comment to be part of the public comment record. See Staff's memorandum to the Council, dated April 19, 2005 for more information on the comments, which has been attached to this record as Exhibit 14,809.

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the **Request for Final Promulgation of Amendments to 105 CMR 170.000, Emergency Medical Services System Regarding Critical Care Service Licensure, EMT Reporting Requirements and Technical Corrections**; that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit No.14,809.**

DETERMINATION OF NEED PROGRAM:

REQUEST FOR APPROVAL TO EXTEND THE EXPIRATION DATE OF THE REVISED DETERMINATION OF NEED GUIDELINES FOR CHRONIC DISEASE AND ACUTE INPATIENT REHABILITATION SERVICES:

Ms. Joan Gorga, Acting Director, Determination of Need Program, explained the proposed changes to the DoN Guidelines for Chronic Disease and Acute Inpatient Rehabilitation Services. Ms. Gorga said, "We request the Public Health Council's approval to extend the expiration date of the revised Determination of Need Guidelines for Chronic Disease and Acute Inpatient Rehabilitation Services from April 27, 2005 to April 27, 2006. The Guidelines allow a one-time increase in beds, so during the proposed extension period only facilities that have not yet added beds under the Guidelines will be eligible to do so. During the period of extension, Department Staff, in consultation with Technical Advisory Group, will reexamine the Guidelines based on the most current utilization data available from the Division of Health Care Finance and Policy (DHCFP); and consider the impact of the new prospective payment reimbursement system, the current nursing shortage, and other relevant factors on the utilization of and need for new services." Council Member Thayer, Jr. asked, "What would be the consequences of the Council not approving the guidelines?" Ms. Gorga responded, "The guidelines would expire and the former guidelines would be in effect. No one could apply for beds or extensions to their projects. This allows for existing providers to apply for beds. The decision was made that, if there was to be expansion, it makes sense for existing providers to provide that expansion." Mr. Thayer, Jr. moved for approval.

After consideration, upon motion made and duly seconded, it was voted: (Commissioner Cote, Ms. Pompeo, Ms. Slemenda, Dr. Sterne, Mr. Thayer in favor and Mr. Sherman abstaining (due to MGL 268A) to approve the Request to Extend the Expiration Date of the Revised Determination of Need Guidelines for Chronic Disease and Acute Inpatient Rehabilitation Services; and that a copy be attached and made a part of this record as **Exhibit No. 14,810.** The revised guidelines become effective immediately upon Council approval.

CATEGORY 1 APPLICATIONS:

PROJECT APPLICATION NO. 4-3A80 OF BRIGHAM AND WOMEN'S HOSPITAL, INC. for new construction of a ten-story (13 level) wing adjacent to the existing hospital campus

Ms. Gorga made introductory remarks. Mr. Jere Page, Senior Analyst, Determination of Need Program, presented the Brigham and Women's Hospital application to the Council. Mr. Page stated, "…The applicant, Brigham and Women's Hospital, is before the Council today seeking approval for construction and renovation of the Hospital's campus in Boston. The project involves new construction of a ten-story, thirteen level wing adjacent to the existing hospital campus to increase the hospital's adult medical and surgical capacity from 451 beds to 471 beds, increase the intensive care capacity from 70 to 80 beds, as well to replace and relocate 80 existing adult medical/surgical beds and 40 intensive care beds. Construction of the new facility will also allow the hospital to expand its surgical capacity from 39 operating rooms to 44 operating rooms, as well as add space for a number of ancillary and ambulatory services. Renovation is also proposed to decompress the existing space involved with medical, surgical and intensive care beds, to provide more patient privacy and increase necessary support space in the hospital's existing facility. All this is intended to correct a number of functional and physical inadequacies inherent in the hospital's existing facility that hinder its ability to meet the needs of its growing patient volume of medical/surgical, intensive care and surgical patients, as well as accommodate changes in medical equipment and technology needed to provide state-of-the art services. Many aspects of the hospital's existing facilities such as patient rooms, intensive care, surgical suites and imaging suites are not properly sized for the complexity of care delivered in a modern academic medical center, and this has had an impact on the hospital's ability to provide timely access to medical care, especially during peak periods. It is expected that the entire project will be completed by October 2008. The recommended maximum capital expenditure is $208,527,190 (July 2004 dollars). This will be financed through an equity contribution of $114.6 million dollars available funds as well as fund raising efforts. The remaining MCE of $93.8 million will be funded by tax exempt bonds issued by the Massachusetts Health and Educational Facilities Authority at an anticipated fixed interest rate of $5.5% for a 25 year term. The funding for the community initiatives portion of this project is significant. More than 7.5 million dollars will be provided over seven years to fund community health services initiatives on health care disparities and work force development in Boston. The payment is to begin within thirty days after DoN approval for all the programs involved with the initiatives. In conclusion, we are recommending approval of the project with the conditions indicated on pages 18-21 in the Staff Summary. The applicant is here to make a brief presentation, take any questions, as well, and of course we would be happy to answer any questions you have." A brief discussion ensued; Council Member Pompeo noted that she was very impressed by the amount of money and range of services in the community initiatives section and by some of the new ideas."

Dr. Gary Gottlieb, President of Brigham and Women's Hospital, addressed the Council, accompanied by Boston Councilman Michael P. Ross and Representative Jeffrey Sanchez of the 15th Suffolk/Norfolk District of Boston and Brookline and Dr. Judith Bigby, a physician at BWH and former Public Health Council Member. Dr. Gottlieb said, "Brigham and Women's Hospital is one of Boston's gems. It is among America's premier academic medical centers. It has the wonderful mission of providing care and trying to bring the best and brightest people to take care of the sickest and the neediest populations, to train the future leaders of health care in this country, and to then

discover science that we can bring to health care to ease pain and ease suffering, and to cure disease. Last year, the hospital served greater than 50,000 admissions, and more than 635,000 outpatient visitors. It has an international reputation for quality care and is one of the leaders in investing in patient safety in health care overall. It has also remained true to its mission that goes back to its forebearer institutions. The Lying-In Hospital for Women and Peter Bent Brigham Hospital founded in 1911, all had a specific mission to care for sick persons in indigent conditions and last year, for example, we were one of the largest providers of free care, providing more than 25 million dollars worth of free care to the people of our community."

Dr. Gottlieb continued, "When I looked at the Brigham and took over the challenge about three years ago, and saw on this site this extraordinary staff, the notion that we were trying to provide state of the art care and to define its future, and to define it in the community, I was also taken aback by the physical plant that was aging, by the crowded circumstances that reflect probably the smallest ratio of square foot per patient, or square foot per unit of service for revenue in all of academic medical care, certainly by two standard deviations below the median in the City of Boston. And so, we tried to figure out how to fix this problem, and address actually the problem that you raised as well, the notion of how to – when the building was first anticipated, the question was, what are we going to do about ambulatory services? We should be bringing more ambulance services to the community. The notion that we were going to drive more cars down Francis Street just seemed ridiculous and it also seemed an inappropriate approach to plan to provide services."

Dr. Gottlieb said further, "…Over the last couple of years, we have worked extensively with the community, and we have identified a number of critical problems. Our occupancy rates in the hospital on a daily basis generally exceed 90%. Efficiency in the hospital is a little bit less than 85%. Many days, we have no available capacity. We have inadequate organization of our diagnostic treatment facilities because of the location and placement of services along different buildings that were built at different times for different purposes, and inpatient rooms, surgical suites, diagnostic facilities don't allow the space to be able to provide the state-of-the art care. Lots of stuff that you need to do in the OR require imaging technology or other technologies that require much more space than was available in the preexisting facilities."

In response to Council Member Sherman's request to the location of the new wing, Dr. Gottlieb said, "At 70 Francis Street, when you look at that big revolving door that is near the corner of Brookline Avenue and Francis Street, there is an empty lot across the street that the community, Harvard and others worked with us to be able to move houses around the block a few years ago and, on that site, we will build a state-of-the-art wing…There will be a bridge that connects the main corridor, or the pike, going right across Francis Street and two full levels under Francis Street that connect…This will replace 80 medical/surgical beds and 48 intensive care beds to allow renovation of the existing tower so that it also starts to meet the space requirements, as well. It will add 20 new medical/surgical beds and 20 new intensive care unit beds and 5 new operating rooms permitting the renovation and enlargement of the existing undersized operating rooms. These will tie under Francis Street and this will allow us to consolidate diagnostic support services and related services in a variety of areas to create higher quality of care, safer care and greater efficiency."

In conclusion, Dr. Gottlieb stated, "Brigham and Women's Hospital remains committed to its mission, remains committed to the future of health care, not only in Boston, but in this country,

remains committed to its community with really an upending desire to mitigate some of the health care disparities that you saw just in that previous presentation. We see the focus on mitigating, for example, the health care disparity that relates to infant mortality rates in the births of African American women as a personal responsibility as an institution that leads this region in terms of deliveries overall…On the community benefit side, I would tell you that we worked very hard with the staff, but we also met with an extensive range of parties in the community, including representatives from the Department of Public Health, the Alliance for Community Health, The Boston Public Health Commission, as well as staff, and we heard from the community that issues of violence, work force development, health care disparities were really the critical issues and they met us right in the middle of our soul of who it is that we are. These health care disparities, and areas of domestic violence, infant mortality, HIV, as well as mental health are critical to us, and they were among the most pressing issues. You can see them reflected in the proposals that were put together. We believe that this proposal did receive support from the Alliance for Community Health and, frankly, it is a wonderful side effect of this project, that we have the ability to invest in these programs, and that investment is reinforced."

State Representative Jeffrey Sanchez of the 15th Suffolk/Norfolk District of Boston/Brookline submitted a letter dated April 15, 2005 asking the Council's approval of the Brigham and Women's Hospital application. He said in part, "It is my understanding that the hospital's DoN application proposes expanding the hospital's number of beds and outpatient service capacity, both of which are essential to the hospital's continued ability to serve the health care needs of this community. As a result, this application is of critical importance to our residents and their health care needs. Moreover, the hospital's DoN application will include important community health initiatives for our residents. Specifically, the community health initiatives planned in connection with this project include initiatives to reduce health care disparities and workforce development among the residents of Mission Hill and Jamaica Plain, and among low-income women and their families….The new services that will be provided if this application is approved will make a positive and important difference for our residents. The hospital is fully committed to the long-term effort of strengthening and supporting this community. I therefore urge the Public Health Council to approve this application so that the hospital may fulfill these important community benefit initiatives for our residents."

Boston Councilman Michael P. Ross submitted a letter of support dated April 15, 2005 for the BWH application. An excerpt follows: "The hospital's DoN application is for the expansion of its inpatient and outpatient service capacity, which is essential to the hospital's continued ability to serve the health care needs of this community. The hospital's DoN application is therefore of critical importance to our residents and their health care needs. In addition, the hospital's DoN application proposes important community health initiatives for our residents, including initiatives to reduce health care disparities and develop the workforce among the residents of Mission Hill and Jamaica Plain, and among low-income women and their families. Specifically, the programs that will be funded by the hospital in connection with this application will work to better track racial and ethnic health outcomes and quality of care in Boston area hospitals, improve the overall quality of care for racial and ethnic minorities, and develop cultural competence of health care workers and health care systems. The programs also will expand the health care work force to include racial and ethnic minorities through programs designed to attract and support youth into better paying, more highly skilled jobs in health care. The proposed programs will also focus on career development and

the creation and support of new positions in important areas such as community health centers and HIV/AIDS programs....Brigham and Women's Hospital is a major health care provider in the Mission Hill area of Boston and has provided quality health care services to residents. In addition, the hospital has a strong history of serving the needs of members of its community through a wide range of important community benefit programs. If the hospital's application is approved, the new services and programs described above will improve the quality of life of our residents. Accordingly, I urge the Public Health Council to approve this DoN application."

Dr. Thomas Sterne, Council Member stated for the record, "As a Partner's employee, I neither heard this conversation, participated in it in any way, shape or form, and I am not prepared to vote." Council Member Sherman made the motion for approval of the project.

After consideration, upon motion made and duly seconded, it was voted (Chair Cote, Ms. Pompeo, Mr. Sherman, Ms. Slemenda, and Mr. Thayer in favor (Dr. Sterne abstaining [due to MGL 268A]) to approve **Project Application No. 4-3A80 of Brigham and Women's Hospital, Inc.**, based on staff findings, with a maximum capital expenditure of $208,527,190 (July 2004 dollars) and first year estimated operating costs of $44,461,673 (July 2004 dollars). A staff summary is attached and made a part of this record as **Exhibit No. 14,811.** As approved, the application provides for new construction of a ten-story building adjacent to the existing Hospital campus to increase the Hospital's adult medical/surgical capacity from 451 beds to 471 beds (an addition of 20 beds), increase intensive care capacity from 70 beds to 80 beds (an addition of 10 beds), as well as replace and relocate 80 existing adult medical/surgical beds and 40 intensive care beds. Construction of the new facility will also allow the Hospital to expand its surgical capacity from 39 operating rooms (ORs) to 44 ORs, as well as add space for ancillary and ambulatory services such as radiation oncology, invasive and non-invasive cardiology services, cardiac/vascular medical/surgical clinics, cardiac pulmonary disease clinics, and staff and family support services. Renovation is also proposed to decompress existing medical/surgical and intensive care beds to provide more patient privacy and increase necessary support space. This Determination is subject to the following conditions:

1. The Hospital shall accept the maximum capital expenditure of $208,527,190 (July 2004 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and .752.

2. The total gross square feet (GSF) for this project shall be 462,640 GSF: 425, 271 GSF for new construction to add and relocate medical/surgical and intensive care bed capacity, increase OR capacity, and add space for ancillary and ambulatory services; and 37,369 GSF for renovation to decompress existing medical/surgical and intensive care beds to provide more patient privacy and increase necessary support space.

3. The Hospital shall contribute 55% in equity ($114,689,955 in July 2004 dollars) to the final approved MCE.

4. With regard to its interpreter service, the Hospital shall:

    - Clarify policies regarding the use of trained interpreters in all interpreting situations.

- Develop a mechanism to capture sessions conducted telephonically and in all languages.
- Provide signage that is clearly posted at all key points of entry into the hospital as required by 105 CMR 130.1101-130.1108.
- Provide outreach to the large non-English speaking communities in the HSA to ensure their knowledge of Brigham and Women's services.
- Provide training on the effective use of interpreters for all clinical staff.

The Hospital shall submit a plan to address these interpreter service elements to the Office of Multicultural Health (OMH) within 120 days of the DoN approval. In addition, the Hospital shall maintain current efforts to provide access to competent interpreter services to LEP patients, notify OMH of any substantial changes to its Interpreter Services Program, provide to OMH a copy of the annual language needs assessment, and submit annual progress reports to OMH on the anniversary date of the DoN approval. Also, the Hospital's Interpreter Services program shall assess the frequency of the use of untrained employees as interpreters and develop a mechanism to limit its use solely to patients identified with life threatening emergent conditions. Further, the Hospital shall follow recommended National Standards for Culturally and Linguistically Appropriate Services ("CLAS") in Health Care.

5. The Hospital shall provide a total of $7,528,059 (July 2004 dollars) over seven years to fund the community health service initiatives on health care disparities and workforce development described below, with payments to begin within thirty days after DoN approval for all programs.

   A. Health Initiatives focused on Disparities

   The Hospital will provide $3,735,000 over seven years toward initiatives that focus on reducing health disparities among some of Boston's most underserved communities and populations, particularly the communities of Mission Hill and Jamaica Plain and the population of low income Boston women and their families.

   Grants to the Alliance for Community Health - $375,000

   The Hospital will provide $25,000 per year for seven years to the Boston Community Health Network Area (the Alliance for Community Health – "CHNA" or the "Alliance") to offer annual grants for community initiatives to address disparities in health and that encourage neighborhood organizations to collaborate on such initiatives. In order to promote collaboration the Alliance will also receive $50,000 per year for four years to fund a staff person to help coordinate grants and other initiatives among neighborhoods. In addition, the Alliance's Operations Committee and the Department's Office of Healthy Communities ("OHC") will meet with representatives from the Hospital on an annual basis to review progress on the grants program. The meeting's agenda will include a report of the Alliance's grants program, the coordinator's position, and a report by the Hospital of its progress on the other community initiatives programs detailed below. The Hospital will also provide annual written progress reports to the OHC regarding all the community initiatives programs.

Infant Mortality - $1,700,000

The Hospital notes that the disparity in infant mortality between black and white infants in Boston has not changed despite decades of efforts toward reducing infant mortality among black babies. To improve this disparity, the Hospital will provide a total of $1,700,000 over seven years to fund a program designed to improve the health of black women, and will collaborate with the Boston Public Health Commission and community-based organizations such as health centers and the Black Women's Health Institute in this effort. This new program will target black women who live in Boston and will focus on providing comprehensive primary, preventive, prenatal and interconception care to women, and will also identify ways to provide personal, family and community support to women.

Community health center case management and health promotion - $560,000

The Hospital will provide $80,000 per year over seven years for a total of $560,000 to support new case managers and health educators at Brookside Community Health Center and Southern Jamaica Plain Health Center in Jamaica Plain. The new staff will work on programs to improve access to care and health promotion for the increasing population of uninsured seeking medical services at the health centers.

HIV/AIDS case management - $150,000

The Hospital will provide $50,000 per year over three years for a total of $150,000 to support a new case manager or health care worker for the Prevention and Access to Care and Treatment (PACT) program, a community oriented program in Boston that provides direct-observed-treatment for HIV infected individuals who have found it difficult to adhere to complicated HIV regimens and have high viral titres.

Domestic Violence Prevention - $600,000

The Hospital will provide a total of $600,000 over seven years to establish a new program in collaboration with Whittier Street Health Center in Boston to address violence prevention among young men fifteen to twenty-five years old.

Underserved persons with mental health diagnoses - $350,000

The Hospital will provide a total of $350,000 over three years to establish an on-site primary care clinic in collaboration with the developers of the Massachusetts Mental Hospital site in Boston that will offer preventive and urgent care services to persons with severe mental illness who typically have significantly higher risk factors for heart disease, diabetes, and cancer, but are likely to receive only intermittent primary and preventive care. The Hospital will also recruit a full-time nurse practitioner and a part-time physician to staff this unit.

B. Workforce Development

The Hospital will provide a total of $2,850,000 over seven years to fund the following workforce development programs:

Community jobs access - $600,000

The Hospital will provide a total of $600,000 over seven years to increase access to employment at the Hospital for residents of the Mission Main housing development on Mission Hill. The Hospital reports that it already has one human resources specialist, who focuses on applicants from the development, and will expand this effort to anyone who lives in Mission Hill, as well as also provide case management services to potential applicants that address problems such as language, literacy, childcare and other problems that prevent individuals from becoming fully employed.

Community health center workforce development - $150,000

The Hospital will provide $50,000 per year over three years for a total of $150,000 to support the Massachusetts League of Community Health Centers ("MLCHC") workforce development program in the city of Boston. This program includes (a) development of a pipeline for professional, administrative, and support staff for community health centers; (b) career development for existing staff; and (c) leadership development to create a pool to replace aging leaders.

Youth programs - $2,100,000

The Hospital will provide a total of $2,100,000 over seven years to develop programs that will engage Boston youth in science and health careers as a means of diversifying the health care workforce in Boston. These funds will be used to create partnerships with elementary and middle schools in Mission Hill and Roxbury and expand upon the Hospital's existing partnerships with high schools in order to (a) supplement and enhance the science instruction that is provided in the schools, (b) introduce students to role models in health care professions, (c) provide job opportunities within the hospital, and (d) offer a competitive scholarship program for students who are entering college with the intention of pursuing careers in healthcare. The program will also provide opportunities for alumni of this initiative to serve as role models for students who are currently involved in the program.

In addition, the Hospital states that it is also committed to the advancement of Hospital staff, and may commit a portion of the funds in this category to initiatives that support additional training, education, and progress of these workers into more highly skilled and more highly paid positions.

C. Other Programs

Sexual Assault Nurse Examiner Program ("SANE")

Upon DoN approval, the Hospital will provide a one-time commitment of $25,000 to the Sexual Assault Nurse Examiner Program ("SANE").

D. Program Support

The Hospital will provide $918,059 for program development and evaluation expertise for the implementation of the above programs. This includes funding for one Hospital staff position, as well as funds to provide community training on health disparities, in partnership with the Alliance, that would assist neighborhood groups in understanding and addressing disparities in their community health planning initiatives.

Staff's recommendation was based on the following findings:

1. The Applicant is proposing new construction of a ten-story building adjacent to the existing Hospital campus to increase the Hospital's adult medical/surgical capacity from 451 beds to 471 beds (an addition of 20 beds), increase intensive care capacity from 70 beds to 80 beds (an addition of 10 beds), as well as replace and relocate 80 existing adult medical/surgical beds and 40 intensive care beds. Construction of the new facility will also allow the Hospital to expand its surgical capacity from 39 operating rooms (ORs) to 44 ORs, as well as add space for ancillary and ambulatory services such as radiation oncology, invasive and non-invasive cardiology services, cardiac/vascular medical/surgical clinics, cardiac pulmonary disease clinics, and staff and family support services. Renovation is also proposed to decompress existing medical/surgical and intensive care beds to provide more patient privacy and increase necessary support space.

2. The health planning process for the project was satisfactory.

3. The proposed new construction and renovation is supported by the Hospital's need to accommodate an increasingly complex patient caseload, as discussed under the HealthCare Requirements factor of the Staff Summary.

4. The project, with adherence to a certain condition, meets the operational objectives factor of the DoN Regulations.

5. The project, with adherence to a certain condition, meets the standards compliance factor of the DoN Regulations.

6. The recommended maximum capital expenditure of $208,527,190 (July 2004 dollars) is reasonable compared to similar, previously approved projects.

7. The recommended operating costs of $44,461,673 (July 2004 dollars) are reasonable compared to similar, previously approved projects.

8. The project is financially feasible and within the financial capability of the applicant.

9. The project meets the relative merit requirements of the DoN Regulations.

10. The proposed community health service initiatives, with adherence to a certain condition, are consistent with the DoN Regulations.

PROJECT APPLICATION NO. 1-3A82 OF COOLEY-DICKINSON HOSPITAL, INC.:

For the record, Council Member Thayer, Jr. left the meeting at this point, before the presentation by Cooley-Dickinson Hospital and therefore did not discuss or vote on this docket item.

Mr. Bernard Plovnick, Consulting Program Analyst, Determination of Need Program, presented the Cooley-Dickinson Hospital application to the Council. Mr. Plovnick stated, "The applicant is seeking the Council's approval today for a project involving significant new construction on the hospital's campus in Northampton. The project scope encompasses construction of a new three-story wing to the existing hospital to accommodate reconfiguration and expansion of its adult medical/surgical beds on the upper level, a new and expanded surgical suite on the ground level, and new central sterile supply department and laboratories on the lower level. In terms of capacity the project would increase the number of operating rooms at Cooley-Dickinson from six to eight, and the number of adult medical/surgical beds at the hospital from 67 to 78. The proposed 11 bed increase in adult medical/surgical beds would be accompanied by replacement of outdated and inefficient 3 and 4-bed patient rooms with private and semi-private rooms. It would enable the hospital's adult service, which over the past four years has experienced annual rates of occupancy in the high 80 to low 90 percent range, to operate more efficiently, to improve the quality of care provided to patients and to accommodate better its anticipated growth and volume."

Mr. Plovnick continued, "The existing operating rooms are over forty-years old and are poorly configured with the larger surgical teams and equipment requirements of contemporary surgical practice. The new surgical suite would eliminate existing deficiencies in space, patient flow and functional adjacencies while alleviating backups and delays in the OR schedule that the applicant claims are currently prevalent at the hospital. The recommended maximum capital expenditure of $38,212,000 is to be financed largely through an equity contribution of 26.2 million dollars from existing fund balances and anticipated operating surpluses, augmented by fund raising efforts expected to provide an additional five million dollars. The remaining twelve million dollars will be funded by tax exempt bonds at an anticipated fixed interest rate of 5.5 percent over a 20 year term. Funding for community health initiatives associated with this project would amount to 1.3 million dollars over five years. The health priorities identified to receive financial support included health care access projects, with an emphasis on linguistic minority populations, health lifestyle programming in the Northampton Public Schools, and community residential substance abuse treatment and support programs. A portion of the funding would be reserved for addressing emerging health issues as determined, or to be determined by the Healthy Communities Committee. This Committee, currently a standing subcommittee of the Cooley-Dickinson Board of Trustees, would be reconstituted, its membership expanded subject to the approval of the Office of Healthy Communities and designated to serve in place of the inactive community Health Network Area Number 3. Staff recommends approval of this project with five

conditions as enumerated on pages11 and 12 of the staff summary. The applicant agrees with these conditions."

Dr. Sterne, Council Member, asked, "Is there an adequate number of funded interpreters at the hospital currently and is there a place to fund an interpreter service?" Ms. Brunilda Torres, Director, Office of Multi-Cultural Health, Department of Public Health, addressed the question. She said, "In terms of staffing and whether a hospital in fact has the staffing model, a contract model, or an employee model is beyond what we perceive as the scope for us to work with a hospital. What the hospital does, too, is they have two vendors that they work with in terms of meeting their interpreter services." Council Member Pompeo stated that she thought it was great that minors are not allowed to be used as interpreters. Ms. Torres stated that the Emergency Room Interpreters Law prohibits the use of children to be used as interpreters and the federal Department of Health and Human Services also recommends that states articulate that policy that children not be used as interpreters.

Mr. Richard Corder, Vice President of Guest Services, Cooley-Dickinson Hospital, accompanied by Mr. Timothy Singleton, Project Manager on this project. Mr. Corder said in part, "In Staff's comments, you have pretty much heard what it is that we plan to do to continue our support and our responsibilities to the provision of health care in our community. It is an exciting community to be a part of, and to be able to serve, have the privilege of serving, and we have been doing it for about 120 years, and we look forward to being able to build a facility on a campus that allows us to continue doing it in a way that provides our community with the state-of-the-art care that they deserve right on their doorstep."

After consideration, upon motion made and duly seconded, it was voted unanimously [Mr. Thayer not present to vote] to approve **Project Application No. 1-3A82 of Cooley Dickinson Hospital, Northampton,** based on staff findings, with a revised maximum capital expenditure of $38,212,000 (July 2004 dollars), and revised first year estimated first year operating costs of $5,582,000 (July 2004 dollars). A staff summary is attached and made a part of this record as **Exhibit No. 14,812**. As approved, this application provides for construction of a 102,562 GSF, three-story addition to the existing hospital facility, an increase in Hospital's medical/surgical capacity from 67 beds to 78 beds (an addition of 11 beds), and an increase in the number of operating rooms from 6 to 8. This Determination is subject to the following conditions:

1. Cooley Dickinson shall accept the maximum capital expenditure of $38,212,000 (July 2004 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and 100.752.

2. The total gross square feet (GSF) for this project shall be 102,562 GSF of new construction to accommodate a 32-bed medical/surgical unit, a surgical unit with 8 operating rooms, PACU, second stage recovery, and shared support, central sterile supply, and laboratory.

3. Cooley Dickinson shall contribute 68% in equity ($26,212,000 in July 2004 dollars) of the final approved maximum capital expenditure.

4. Cooley Dickinson shall have in place the following missing elements of a professional medical interpreter service:

   - Policies clearly stating that the use of minors for interpreting is prohibited.

   - Policies stating that staff should not encourage or suggest the use of family members as interpreters for patients.

   - Assurance that all staff and contracted interpreters are trained.

   - Demographic data collection that includes race and ethnicity as required by 105 CMR 130.1101-130.1108.

   Further, Cooley-Dickinson shall assure consistency of interpreter coverage across all campuses and programs and follow recommended National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care (http://www.omhrc.gov/omh/programs/finalreport.pdf). Cooley Dickinson shall notify the Office of Multicultural Health of any substantial change to its Interpreter Services Program. Within 90 days of DoN Approval, Cooley Dickinson shall submit a plan for improvement to the Office of Multicultural Health. Cooley-Dickinson shall provide annual progress reports to the Office of Multicultural Health on the anniversary date of DoN Approval.

5. Cooley Dickinson shall provide a total of $1,300,000 (July 2004 dollars) over a five-year period to fund community health service initiatives with payment to begin within 30 days following DoN Approval. This amount will include:

   - A one time contribution of $15,000 to fund development and support of a community coalition that expands the existing Cooley Dickinson Healthy Communities Committee with membership approved by the Office of Healthy Communities.

   - $162,000 per year to health access projects that will contain up to $62,000 in interpreter support for linguistic minorities in physician offices and other health care settings.

   - $15,000 per year for healthy lifestyle programs or projects in the Northampton Public Schools, based on best or promising practices.

   - $50,000 per year to support the social model community residential treatment program for residents of Hampshire County who are in need of substance abuse support and treatment.

- $30,000 per year to address emerging issues as determined by the expanded Healthy Communities Committee in their ongoing assessment of community health needs.

Cooley Dickinson's Healthy Communities Committee shall be expanded and designated, in place of the inactive CHNA #3, to distribute this funding by developing and utilizing a transparent allocation process and to measure outcomes for funded projects and programs. The Healthy Communities Committee shall conduct an annual meeting to report its findings both to the state Office for Healthy Communities and to the community at large.

This approval was based on the following staff findings:

1. Cooley-Dickinson is proposing new construction of a three-story addition to its existing facility to accommodate: a 32-bed medical/surgical patient unit (11 new, 21 replacement beds); a surgical suite with 8 operating rooms (6 replacement, 2 new), PACU and second stage recovery; central sterile supply department with dedicated sterile and soiled elevators; and a new central laboratory replacing existing services.

2. The health planning process for this project was adequate.

3. The proposed new construction and renovation is supported by current and projected acute care utilization. Specifically, the addition of 11 adult medical/surgical and 2 operating rooms are necessary for Cooley Dickinson to operate effectively and efficiently in accommodating reasonable projections of continuing growth in demand for its services, as discussed in the Health Care Requirements section of this staff summary.

4. The project, with adherence to a certain condition, meets the operational objectives factor of the DoN Regulations.

5. The project, with adherence to a certain condition, meets the standards compliance factor of the DoN Regulations.

6. The recommended maximum capital expenditure of $38,212,000 (July 2004 dollars) is reasonable compared to the Marshall Valuation Service standard and to similar, previously approved projects.

7. The recommended operating costs of $5,582,000 (July 2004 dollars) are reasonable compared to similar, previously approved projects.

8. The project is financially feasible and within the financial capability of the Applicant.

9. The project meets the relative merit requirements of the DoN Regulations.

10. The proposed funding of community health service initiatives, with adherence to a certain condition, is consistent with DoN Regulations.

The meeting adjourned at 11:40 a.m.

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Paul J. Cote, Jr., Chair

LMH/lmh